

Johnson City Medical Center
400 North State of Franklin Road
Johnson City, TN 37604

Name: [REDACTED]	MR Number: [REDACTED]
DOB: [REDACTED]	Admit Date: 10/17/2012
Account Number: [REDACTED]	Room: [REDACTED]
Pt. Status: IA	Hosp Svc. Code: MED
MD ID: [REDACTED]	Document ID: [REDACTED]

History and Physical Report

ADMITTING PHYSICIAN: [REDACTED]

DATE OF SERVICE: 10/17/2012

PRIMARY CARE PHYSICIAN: [REDACTED]

NEUROLOGIST: [REDACTED]

HISTORY OF PRESENT ILLNESS: [REDACTED] a 37-year-old female with a past medical history of mental retardation (secondary to premature birth), epilepsy, hypothyroidism, "facial tics." The patient was brought here by her mother for weakness and lethargic activity. History was acquired from chart, records and from mother.

The mother reports that the patient was doing well prior to yesterday. She only noticed that the patient was "quiet at the school on Monday." Mother denied noticing any other symptoms or signs. Then on yesterday she reported that the patient had no energy and patient "her eyes looked weak." She reported that she laid in bed all day and actually urinated on herself in the bed (which is not normal for her). The patient was not as talkative as usual and was weak and having trouble walking. She admits that the patient had some "shakes" and shaking movements performing activity due to weakness and not necessarily due to tremors. Normally the patient is more independent with daily activities (dressing, bathing, eating, grooming, et cetera). However, she needed assistance with these activities on yesterday.

Mother reports that the patient did not complain of chest pain, abdominal pain, nausea, vomiting, headaches, dyspnea, fever, chills. She does have occasional cough upon examination, however, the mother denies any sputum production. She reports that she does not think that the patient had any issues or difficulties with swallowing or eating. Mother is unaware of any sick contacts. The patient does attend adult day care facility three times a day out the week. ER reports that the patient did have some desaturations into the 80s. The mother of the patient denies any recent falls or trauma to the chest. Last fall was approximately two months ago and the patient sprained her wrist and hurt her hip and the patient subsequently went to [REDACTED] and had x-rays, which only showed sprained left wrist (that was per mother).

PAST MEDICAL HISTORY:

1. Epilepsy (complex partial epilepsy).
2. Static encephalopathy.
3. History of dysphagia. EGD with dilatation on 9/13/2005 (also revealed lower esophageal ring and small hiatal hernia).

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4. Diminutive polyp, gastric cardia biopsy, benign fundic polyp, negative Helicobacter, negative intestinal metaplasia, dysplasia, malignancy.
5. Hypothyroidism.
6. Facial tics.
7. Mental retardation secondary to premature birth (patient born at 5 and half months, 2 pounds 13 ounces).
8. Dyslipidemia.

PAST SURGICAL HISTORY:

1. Patient had a trach at one year old due to difficulty breathing.
2. Feeding tube that was placed in the "top of her head as a baby."
3. No other surgeries.

SOCIAL HISTORY: The patient lives in Johnson City with her mother, attends Adult Day Care two days a week. Denies tobacco, alcohol and illicit drug use.

FAMILY HISTORY:

1. Mother diabetes mellitus.
2. Father heart disease, massive MI at the age of 39 from which he passed away from.
3. Denies lung abnormalities or other mental retardation in the family history.

ALLERGIES: No known drug allergies.

MEDICATIONS: The patient takes,

1. Vitamin D 400 units orally twice daily every a.m. and 800 units orally at bedtime.
2. Divalproex 500 mg orally every a.m. and 1000 mg orally at bedtime.
3. Levothyroxine 75 mcg orally daily.
4. Lovastatin 60 mg orally at bedtime.
5. Fish oil.
6. Topiramate 200 mg orally twice daily.

REVIEW OF SYSTEMS: 12-point review of systems performed which is negative except for HPI.

NEUROLOGICAL: Mental retardation, epilepsy, encephalopathy as noted above. Patient appears to be weak, however, mother noticed that strength is close to her baseline.

ENDOCRINE: Hypothyroidism as mentioned above.

CARDIO: No abnormalities noted.

PULMONARY: Pneumonia in right hemithorax per x-ray. No crackles, labored breathing or dyspnea was noted.

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GI: No abdominal pain, no problems with movement. History of dysphagia as noted above.
HEMATOLOGIC: No abnormalities noted.

PHYSICAL EXAMINATION:

VITAL SIGNS: 130/91, heart rate 133, respiratory rate 18. Temperature 101.5. Patient was saturating 94% on room air.

GENERAL: The patient was in no acute distress upon interview. Mental retardation, the patient is pleasant unable to answer questions to time and place. The patient was oriented to person.

HEENT: Normocephalic, atraumatic. Pupils are equal, round and reactive to light. No lymphadenopathy. No JVD noted. No difficulty hearing. The patient is obese.

CARDIOVASCULAR: Regular rate and rhythm. No murmurs, rubs or gallops were appreciated.

PULMONARY: Exam, decreased breath sounds on the right, no wheezing, rhonchi or rales were noted.

ABDOMEN: Nontender, obese, positive bowel sounds, soft.

EXTREMITIES: Mild pedal edema, positive pulses, no cyanosis, no clubbing. 4/5 strength. The patient is not able to fully follow commands. When asked to squeeze hand, squeezed intermittently. The patient did appear to be too weak to stand. Lethargic, fatigue, yet arousable.

NEUROLOGIC: Normal reflexes, patient does not fully follow commands accurately, unable to stand and examine secondary to fatigue. Dysarthric speech, no tremors were noted.

LABS: Sodium 137, potassium 3.7, chloride 107, bicarbonate 22, BUN 11, creatinine 0.98, glucose 109, albumin 3.3, AST 96, WBC 5.0, hemoglobin 13.2, platelets 103. Hematocrit 39.9. Urinalysis, protein 30, ketones 40. Moderate blood, 5 to 10 RBCs, possibility of traumatic Foley placement. 2 out of 5 epithelial cells and trace of mucus. Chest x-ray abnormal, right hemithorax, large effusion.

ASSESSMENT/PLAN: [REDACTED] is a 37-year-old female who presented with:

1. Weakness and lethargy. On x-ray noted right hemithorax and large pleural effusion. Community acquired pneumonia versus aspiration pneumonia versus PE versus pleural effusion.
 - A. Will admit patient to [REDACTED] med service with telemetry under the care of [REDACTED]
 - B. Will keep patient NPO until swallowing evaluation.
 - C. Follow procedure aspiration precautions.
 - D. Also to keep O2 sats greater than 90%, I&Os, Foley catheter placed.
 - E. ABG breathing treatments and incentive spirometry.
 - F. CT chest rule out PE.
 - G. Ceftriaxone and azithromycin to cover community acquired and aspiration pneumonia.
 - H. Blood cultures, urine cultures, sputum cultures.
 - I. Will obtain EKG, Legionella, urine Strep pneumoniae, mycoplasma antibodies.
 - J. Consult pulmonary for right hemithorax possibly for thoracentesis.
2. Complex partial seizure, mental retardation, continue Depakote and topiramate, check B12, folate

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levels, will check Depakote and topiramate levels. Will obtain records from [REDACTED] office.

3. Hypothyroidism continue levothyroxine, check TSH levels.
4. Dyslipidemia. Continue atorvastatin and fish oil. Check fasting lipid profile in the a.m.
5. Dysphagia history, swallow evaluation to be performed prior to advancing diet.
6. Vitamin D deficiency, continue Vitamin D, will check Vitamin D levels.
7. Occasional cough, provide the patient with guaifenesin.
8. Place the patient on full dose Lovenox until ruled out for PE. Protonix and GI prophylaxis.

Patient is full code.

DISPOSITION: Home with caretaker (mother).

Will discuss with attending [REDACTED] and medical team in the a.m.

Bhuvana Guha, M.D.

Dictated By: [REDACTED]

cc: [REDACTED]

Bhuvana Guha, M.D.

D: 10/17/2012 20:08

T: 10/18/2012 09:56

Signed by BHUVANA GUHA, MD on 21-Oct-2012 11:53:09 -04:00

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Page 4 of 4